

2010 Medical Plans Comparison Chart for Medicare Retirees

UnitedHealthcare Senior Premier PPO			Presbyterian MediCare PPO (NM) <small>Pending CMS approval</small>		Lovelace Senior Plan (NM) <small>Pending CMS approval</small>	Kaiser Senior Advantage Plan (CA) <small>Pending CMS approval</small>
Type of Plan	Preferred Provider Organization – PPO (In order to receive full benefits, you must be enrolled in Medicare Parts A and B)		Medicare Advantage PPO Requires assignment of Medicare benefits (Must be enrolled in Medicare Parts A and B)		Medicare Advantage HMO – Health Maintenance Organization Requires assignment of Medicare benefits (Must be enrolled in Medicare Parts A and B)	Medicare Advantage HMO – Health Maintenance Organization Requires assignment of Medicare benefits (Must be enrolled in Medicare Parts A and B)
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only	In-Network Only
Annual Calendar Year Deductible	Individual: N/A Family: N/A		Individual: N/A Family: N/A		Individual: N/A Family: N/A	Individual: None Family: None
Annual Calendar Year Out-of-Pocket Maximum	Individual: \$1,000 per person		Individual: N/A Family: N/A		Individual: N/A Family: N/A	Individual: \$1,500 Family: \$3,000 (two or more) Member is responsible for tracking annual out-of-pocket costs through accumulation of Kaiser receipts Excludes prescription copays
Preventive Care						
Annual Routine Physical	No Charge	20% of U&C	No copay	\$35 copay	\$10 copay	\$15 copay
Immunizations/Flu Shots	No Charge	20% of U&C	No copay	No copay	No copay	No copay
Certain Cancer Screenings	No Charge	20% of U&C	No copay	No copay	\$0-\$50 copay	No copay
Vision Screening	Not Available	Not Available	\$30 copay (Optometrist only)	\$55 copay (Optometrist only)	\$20 copay for each Medicare covered visit \$30 copay routine annual exam \$150 eyewear benefit	\$15 copay
Outpatient Services						
Office Visit – PCP	20% of negotiated fees	20% of U&C	\$10 copay	\$35 copay	\$10 copay	\$15 copay
Office Visit – Specialist	20% of negotiated fees	20% of U&C	\$30 copay	\$55 copay	\$20 copay	\$15 copay
Urgent Care	20% of negotiated fees	20% of U&C	\$10 copay per visit	\$40 copay per visit	\$20 copay/\$50 copay	\$15 copay
Emergency Room	20% of negotiated fees	20% of U&C	\$50 copay per visit Not waived if admitted	\$50 copay per visit Not waived if admitted	\$50 per visit Waived if admitted	\$50 per visit Waived if admitted within 24 hours with same condition
Outpatient Surgery	20% of negotiated fees	20% of U&C	\$150 copay	20% of Medicare allowable	\$50 copay	\$50 copay
Chiropractic	20% of negotiated fees \$1000 annual maximum combined in and out of network	20% of U&C \$1000 annual maximum combined in and out of network	\$30 copay Manual manipulation of the spine to correct subluxation only	\$55 copay Manual manipulation of the spine to correct subluxation only	\$20 copay	\$15 copay
Acupuncture	20% of negotiated fees \$1000 annual maximum combined in and out of network	20% of U&C \$1000 annual maximum combined in and out of network	Acupuncture not covered	Acupuncture not covered	\$15 copay	\$15 copay
Speech, Physical/ Occupational Therapy	20% of negotiated fees	20% of U&C	\$10 copay Prior authorization required	\$35 copay If you do not receive prior authorization for out-of-network services, your out-of-pocket cost sharing could be higher. Prior authorization required	\$10 copay	\$15 copay Maximum of 60 consecutive days/condition/lifetime
Lab/Radiology (Outpatient)	20% of negotiated fees	20% of U&C	No copay	10% lab/x-ray 20% radiation therapy	\$0 lab/general x-ray \$20 radiation therapy \$50 CT/MRI/PET	No copay
Hospital Services						
Inpatient Admit	20% of negotiated fees	20% of U&C	\$350 deductible Deductible per benefit period. Benefit period begins the day you are admitted to a hospital or skilled nursing facility and ends when you have not received hospital care for 60 days in a row. Prior authorization required	\$750 deductible Deductible per benefit period. Benefit period begins the day you are admitted to a hospital or skilled nursing facility and ends when you have not received hospital or skilled nursing care for 60 days in a row. Prior authorization required. If you do not receive prior authorization for out-of-network services, your out-of-pocket cost sharing could be higher.	\$200 copay Benefit period begins the day you are admitted to a hospital or skilled nursing facility and ends when you have not received hospital or skilled nursing care for 60 days in a row. Prior authorization required	\$250 copay
Ambulance	20% of negotiated fees	20% of U&C	\$75 copay (Not waived if admitted)	\$50 copay (Not waived if admitted)	\$75 copay	\$50 copay
Hospice (Inpatient)	20% of negotiated fees	20% of U&C	Covered by Medicare	Covered by Medicare	No copay in Medicare-certified facility	No copay
Skilled Nursing Facility	20% of negotiated fees	20% of U&C	Days 1-20: \$0 copay per day Days 21-100: \$75 copay per day Benefit period begins 1 st day of hospitalization or skilled nursing facility confinement; new benefit period begins with 60 day lapse between confinements. 100 days per benefit period. Prior authorization required	Days 1-20: \$0 copay per day Days 21-100: \$125 copay per day Benefit period begins 1 st day of hospitalization or skilled nursing facility confinement; new benefit period begins with 60 day lapse between confinements. If you do not receive prior authorization for out-of-network services, your out-of-pocket cost sharing could be higher. 100 days per benefit period. Prior authorization required	No copay Benefit period begins 1 st day of hospitalization or skilled nursing facility confinement; new benefit period begins with 60 day lapse between confinements. 100 days per benefit period. Prior authorization required	No copay for up to 100 days per benefit period
Other Benefits						
Durable Medical Equipment/ External Prosthetic Appliances	20% of negotiated fees	20% of U&C	\$10 (DME) \$10 (EPA)	\$50 for each piece if prior authorization received	\$0	No copay

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Type of Plan	Preferred Provider Organization – PPO (In order to receive full benefits, you must be enrolled in Medicare Parts A and B)		Medicare Advantage PPO Requires assignment of Medicare benefits (Must be enrolled in Medicare Parts A and B)		Medicare Advantage HMO – Health Maintenance Organization Requires assignment of Medicare benefits (Must be enrolled in Medicare Parts A and B)	Medicare Advantage HMO – Health Maintenance Organization Requires assignment of Medicare benefits (Must be enrolled in Medicare Parts A and B)
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only	In-Network Only
Prescription Drugs						
Retail						
• Generic	20% of retail network price with a \$6 minimum and \$12 maximum Up to 30-day supply	50% retail network price less applicable minimum copay Up to 30-day supply	\$5 copay Copays until you reach \$4,550 in out-of-pocket costs. Beyond the \$4,550, refer to Evidence of Coverage. Maximum of 30 days	Generally, prescription drugs are only covered at an out-of-network pharmacy in limited circumstances when a network pharmacy is not available. Please refer to the Evidence of Coverage for these limited circumstances.	\$5 copay Copays until you reach \$4,550 in out-of-pocket costs. Beyond the \$4,550, refer to Evidence of Coverage. Maximum of 30 days	\$10 copay Up to 30-day supply
• Brand-Name	Preferred—30% of retail network price with a \$25 minimum and \$40 maximum Up to 30-day supply	50% retail network price less applicable minimum copay Up to 30-day supply	\$35 copay Copays until you reach \$4,550 in out-of-pocket costs. Beyond the \$4,550, refer to Evidence of Coverage. Maximum of 30 days	Generally, prescription drugs are only covered at an out-of-network pharmacy in limited circumstances when a network pharmacy is not available. Please refer to the Evidence of Coverage for these limited circumstances.	\$32 copay Copays until you reach \$4,550 in out-of-pocket costs. Beyond the \$4,550, refer to Evidence of Coverage. Maximum of 30 days	\$20 copay Up to 30-day supply
	Non Preferred—40% of retail network price with a \$40 minimum and \$60 maximum Up to 30-day supply	50% retail network price less applicable minimum copay Up to 30-day supply	\$55 copay Copays until you reach \$4,550 in out-of-pocket costs. Beyond the \$4,550, refer to Evidence of Coverage. Maximum of 30 days	Generally, prescription drugs are only covered at an out-of-network pharmacy in limited circumstances when a network pharmacy is not available. Please refer to the Evidence of Coverage for these limited circumstances.	\$62 copay Copays until you reach \$4,550 in out-of-pocket costs. Beyond the \$4,550, refer to Evidence of Coverage. Maximum of 30 days	N/A
Mail Order						
• Generic	20% of mail order price with a \$12 minimum and a \$24 maximum Up to 90-day supply	N/A	\$10 copay Copays until you reach \$4,550 in out-of-pocket costs. Beyond the \$4,550, refer to Evidence of Coverage. Maximum of 90 days	Generally, prescription drugs are only covered at an out-of-network pharmacy in limited circumstances when a network pharmacy is not available. Please refer to the Evidence of Coverage for these limited circumstances.	\$15 copay Copays until you reach \$4,550 in out-of-pocket costs. Beyond the \$4,550, refer to Evidence of Coverage. Maximum of 90 days	\$20 copay Up to 100-day supply
• Brand-Name	Preferred—30% of mail order price with a \$50 minimum and a \$80 maximum Up to 90-day supply	N/A	Preferred—\$87.50 copay Copays until you reach \$4,550 in out-of-pocket costs. Beyond the \$4,550, refer to Evidence of Coverage. Maximum of 90 days	Generally, prescription drugs are only covered at an out-of-network pharmacy in limited circumstances when a network pharmacy is not available. Please refer to the Evidence of Coverage for these limited circumstances.	Preferred—\$96 copay Copays until you reach \$4,550 in out-of-pocket costs. Beyond the \$4,550, refer to Evidence of Coverage. Maximum of 90 days	\$40 copay Up to 100-day supply
	Non Preferred—40% of mail order price with a \$80 minimum and a \$120 maximum Up to 90-day supply	N/A	Non Preferred—\$165 copay Copays until you reach \$4,550 in out-of-pocket costs. Beyond the \$4,550, refer to Evidence of Coverage. Maximum of 90 days	Generally, prescription drugs are only covered at an out-of-network pharmacy in limited circumstances when a network pharmacy is not available. Please refer to the Evidence of Coverage for these limited circumstances.	Non Preferred—\$186 copay Copays until you reach \$4,550 in out-of-pocket costs. Beyond the \$4,550, refer to Evidence of Coverage. Maximum of 90 days	N/A
Specialty Drugs	Refer to the Retiree Open Enrollment book for more information	N/A	25% coinsurance Maximum of 30 days	Generally, prescription drugs are only covered at an out-of-network pharmacy in limited circumstances when a network pharmacy is not available. Please refer to the Evidence of Coverage for these limited circumstances.	\$62 copay Maximum of 30 days	N/A
Behavioral Health						
Mental Health						
• Inpatient	20% of negotiated fees	20% of U&C	\$350 deductible Prior authorization required. Deductible per benefit period. Benefit period begins the day you are admitted to a hospital or skilled nursing facility and ends when you have not received hospital care for 60 days in a row. 190-day lifetime limit	\$750 deductible Deductible per benefit period. Benefit period begins the day you are admitted to a hospital or skilled nursing facility and ends when you have not received hospital care for 60 days in a row, if prior authorization received. If you do not receive prior authorization for out-of-network services, your out-of-pocket cost sharing could be higher. 190-day lifetime limit	\$200 copay Prior authorization required. Deductible per benefit period. Benefit period begins the day you are admitted to a hospital or skilled nursing facility and ends when you have not received hospital or skilled nursing care for 60 days in a row. 190-day lifetime limit	\$250 copay
• Outpatient	20% of negotiated fees	20% of U&C	\$30 copay	50% of Medicare allowable	\$20 copay/individual therapy \$20 copay/group visit	\$15 copay
Substance Abuse						
• Inpatient	20% of negotiated fees	20% of U&C	See "Mental Health" above	See "Mental Health" above	See "Mental Health" above	\$250 copay per admission
• Outpatient	20% of negotiated fees	20% of U&C	\$30 copay for individual or group therapy	50% of Medicare allowable	\$20 copay/individual visit \$15 copay/group visit	\$15 copay Unlimited visits

This information is a condensed summary and does not replace or modify the Summary Plan Description (SPD) or Evidence of Coverage (EOC) for the plans. If there is any discrepancy in the information on this grid, the SPD or the EOC, the SPD or EOC supercedes.

2010 Medical Plans Comparison Chart for Pre-Medicare Retirees

UnitedHealthcare Premier PPO			Sandia Total Health (administered by UnitedHealthcare)		CIGNA In-Network Plan	Kaiser (CA) HMO
Type of Plan	Preferred Provider Organization – PPO		Consumer Directed Health Plan (CDHP)		Exclusive Provider Organization (EPO) (An HMO “Look - Alike”)	Health Maintenance Organization – HMO
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	In-Network Only
Annual Calendar Year Deductible	Individual: \$250 Family: \$750 (excludes prescription drugs)	Individual: \$750 Family: \$2,250 (excludes prescription drugs)	\$750 maximum per person up to \$1,500 Retiree + spouse or child(ren) up to \$2,250 Retiree + spouse + child(ren) (excludes prescription drugs)	\$2,000 maximum per person up to \$4,000 Retiree + spouse or child(ren) up to \$6,000 Retiree + spouse + child(ren) (excludes prescription drugs)	Individual: None Family: None	Individual: None Family: None
Annual Calendar Year Out-of-Pocket Maximum	Individual: \$1,750 Family: \$3,500 (includes deductible) Prescription Drugs: No out-of-pocket maximum	Individual: \$3,500 Family: \$7,000 (includes deductible) Prescription Drugs: No out-of-pocket maximum	\$2,750 per person \$5,500 Retiree + spouse or child(ren) \$8,250 Retiree + spouse + child(ren) (includes deductible) Prescription Drugs: \$1,500 individual out-of-pocket maximum	\$6,000 per person \$12,000 Retiree + spouse or child(ren) \$18,000 Retiree + spouse + child(ren) (includes deductible) Prescription Drugs: No out-of-pocket maximum	Individual: \$1,500 Family: \$3,000 Prescription Drugs: No out-of-pocket maximum	Individual: \$1,500 Family: \$3,000 (two or more) Member is responsible for tracking annual out-of-pocket costs through accumulation of Kaiser receipts Prescription Drugs: No out-of-pocket maximum
Health Reimbursement Account	N/A	N/A	\$250 retiree only / \$500 retiree + spouse or child(ren) \$750 retiree + spouse + child(ren) (HRA amount(s) reduced by \$250 if retiree does not complete Health Assessment and Biometric Screening)		N/A	N/A
Preventive Care						
Annual Routine Physical	No Charge	30% of eligible expenses Subject to deductible	No cost to you	40% of eligible expenses Subject to deductible	No copay	\$20 copay
Immunizations/Flu Shots						No copay
Certain Cancer Screenings						No copay
Outpatient Services						
Office Visit – PCP	\$20 copay Lab, radiology, supplies, diagnostic tests and injections, other than immunizations, performed in a physician's office will result in a 15% coinsurance which is subject to deductible	30% of eligible expenses Subject to deductible	20% of negotiated fees Subject to deductible	40% of eligible expenses Subject to deductible	\$20 copay	\$20 copay
Office Visit – Specialist	\$35 copay Lab, radiology, supplies, diagnostic tests and injections, other than immunizations, performed in a physician's office will result in a 15% coinsurance which is subject to deductible				\$30 copay	\$20 copay
Urgent Care	15% of negotiated fees Subject to deductible	30% of eligible expenses Subject to deductible			\$40 copay	\$20 copay
Emergency Room					\$125 per visit	\$100 per visit
Outpatient Surgery					\$125 copay	\$100 copay per procedure
Allergy Treatment <ul style="list-style-type: none">• Testing					\$30 copay	\$20 copay
<ul style="list-style-type: none">• Serum					No copay	No copay
<ul style="list-style-type: none">• Shot Only					\$10 copay	\$5 copay
Chiropractic	15% of negotiated fees Subject to deductible \$1000 maximum combined in and out of network	30% of eligible expenses Subject to deductible \$1000 maximum combined in and out of network	20% of negotiated fees Subject to deductible Calendar year maximum of \$750 combined for in-network and out-of-network charges.	40% of eligible expenses Subject to deductible Calendar year maximum of \$750 combined for in-network and out-of-network charges.	\$20 copay Combined maximum of 60 visits/calendar year for Chiropractic, Acupuncture, Speech Therapy, Physical Therapy, and Occupational Therapy	\$15 copay Chiropractic care with a maximum of 30 visits/ CY
Acupuncture	15% of negotiated fees Subject to deductible \$1000 maximum combined in and out of network	30% of eligible expenses Subject to deductible \$1000 maximum combined in and out of network	20% of negotiated fees Subject to deductible Calendar year maximum of \$750 combined for in-network and out-of-network charges.	40% of eligible expenses Subject to deductible Calendar year maximum of \$750 combined for in-network and out-of-network charges.		\$20 copay Acupuncture allowed with referral for Medical Management of Chronic Pain only
Speech, Physical/ Occupational Therapy	15% of negotiated fees Subject to deductible	30% of eligible expenses Subject to deductible	20% of negotiated fees Subject to deductible	40% of eligible expenses Subject to deductible		\$20 copay Maximum of 60 consecutive days/condition/ lifetime
Lab/Radiology (Outpatient)	15% of negotiated fees Subject to deductible	30% of eligible expenses Subject to deductible	20% of negotiated fees Subject to deductible	40% of eligible expenses Subject to deductible		No copay

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Type of Plan	Preferred Provider Organization – PPO		Consumer Directed Health Plan (CDHP)		Exclusive Provider Organization (EPO) (An HMO “Look - Alike”)	Health Maintenance Organization – HMO
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	In-Network Only
Hospital Services						
Inpatient Admit	15% of negotiated fees Subject to deductible	30% of eligible expenses Subject to deductible	20% of negotiated fees Subject to deductible	40% of eligible expenses Subject to deductible	\$400 per admission	\$500 per admission
Ambulance					\$75 copay	\$75 copay
Hospice (Inpatient)					No copay	No copay
Skilled Nursing Facility					No copay Limit of 60 days/CY	No copay Benefit period begins 1 st day of hospitalization or skilled nursing facility confinement; new benefit period begins with 60-day lapse between confinements
Other Benefits						
Durable Medical Equipment/External Prosthetic Appliances	15% of negotiated fees Subject to deductible Pre-authorization required for over \$1000 purchased or cumulative rental value	30% of eligible expenses Subject to deductible Pre-authorization required for over \$1000 purchased or cumulative rental value	20% of negotiated fees Subject to deductible Pre-authorization required for over \$1000 purchased or cumulative rental value.	40% of eligible expenses Subject to deductible Pre-authorization required for over \$1000 purchased or cumulative rental value.	No copay \$200 annual deductible for external prosthetic appliances Benefit is unlimited	No copay
Prescription Drugs						
Retail						
• Generic	20% of retail network price with a \$6 minimum and \$12 maximum Up to 30-day supply	50% retail network price less applicable minimum copay Up to 30-day supply	20% of retail network price	50% retail network price	20% of retail network price with a \$6 minimum and \$12 maximum Up to 30-day supply	\$10 copay Up to 30-day supply
• Brand-Name	Preferred—30% of retail network price with a \$25 minimum and \$40 maximum Up to 30-day supply	50% retail network price less applicable minimum copay Up to 30-day supply	Preferred—30% of retail network price		Preferred—30% of retail network price with a \$25 minimum and \$40 maximum Up to 30-day supply	\$30 copay Up to 30-day supply
	Non Preferred—40% of retail network price with a \$40 minimum and \$60 maximum Up to 30-day supply	50% retail network price less applicable minimum copay Up to 30-day supply	Non Preferred—40% of retail network price		Non Preferred—40% of retail network price with a \$40 minimum and \$60 maximum Up to 30-day supply	N/A
Mail Order						
• Generic	20% of mail order price with a \$12 minimum and a \$24 maximum Up to 90-day supply	N/A	20% of mail order price	N/A	20% of mail order price with a \$12 minimum and a \$24 maximum Up to 90-day supply	\$20 copay Up to 100-day supply
• Brand-Name	Preferred—30% of mail order price with a \$50 minimum and a \$80 maximum Up to 90-day supply	N/A	Preferred—30% of mail order price	N/A	Preferred—30% of mail order price with a \$50 minimum and a \$80 maximum Up to 90-day supply	\$60 copay Up to 100-day supply
	Non Preferred —40% of mail order price with a \$80 minimum and a \$120 maximum Up to 90-day supply	N/A	Non Preferred—40% of mail order price	N/A	Non Preferred —40% of mail order price with a \$80 minimum and a \$120 maximum Up to 90-day supply	N/A
Specialty Drugs	Refer to the Retiree Open Enrollment booklet	N/A	Refer to the Retiree Open Enrollment booklet		Refer to the Retiree Open Enrollment booklet	N/A
Behavioral Health						
Mental Health						
• Inpatient	15% of negotiated fees Subject to deductible	30% of eligible expenses Subject to deductible	20% of negotiated fees Subject to deductible	40% of eligible expenses Subject to deductible	\$400 per admission	\$500 copay
• Outpatient	\$35 copay	30% of eligible expenses Subject to deductible	20% of negotiated fees Subject to deductible	40% of eligible expenses Subject to deductible	\$30 copay	\$20 copay
Substance Abuse						
• Inpatient	15% of negotiated fees Subject to deductible	30% of eligible expenses Subject to deductible	20% of negotiated fees Subject to deductible	40% of eligible expenses Subject to deductible	\$400 per admission	\$500 copay
• Outpatient	\$35 copay	30% of eligible expenses Subject to deductible	20% of negotiated fees Subject to deductible	40% of eligible expenses Subject to deductible	\$30 copay	\$20 copay